

“Atypical” or “Mixed” Psychosis

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INTRODUCTION

Many difficult problems still remain unsolved today, from the psychopathological and diagnostic viewpoint, in the domain of psychiatry. Foremost among them is the question of what constitutes schizophrenia. The acute problem facing a psychiatrist almost daily at his clinic is not only the decision of whether or not the patient in front of him is psychiatric patient but also the necessity of establishing a workable system of diagnosis so that a successful treatment, course and prognosis of the patient's disease can be achieved.

With regard to this problem, I keenly feel that the age of Kraepelin is not over yet¹⁾. That is to say, there is still a strong tendency to treat the patient as either a schizophrenic or a manic depressive depending upon the specific features of each disease that are observed. This continues despite the fact that these features, not being absolutely ubiquitous or consistent, give rise to many diagnostic problems; in endogenous psychosis with schizophrenia on the one side and manic-depressive psychosis on the other.

CASE REPORT

The patient was a 30 years old unmarried woman.

Past history: Not remarkable

Family history: Her cousin (female) on the mother's side committed suicide when she was a 4th years university student. No details are known, but it is suspected that she was a schizophrenic.

Growth history: The patient is the youngest among ten siblings, with five elder brothers and four elder sisters. She was delivered smoothly at full-term and fed on mother's milk. She showed no abnormalities in infancy or growth.

Her father, a third generation master carpenter, was meticulous and rigid, but was of a gentle nature, it is said. He died of encephalomalacia nine years ago. The eldest son has since entered his father's profession

to become a fourth generation carpenter.

She has little contact with the eldest brother, partly because of their age difference, although she receives a good deal of help from him financially. Her mother has been weak and often bodridden since her middle years. Her married eldest sister often acted as a mother and took care of her in various ways. Other elder brothers and sisters all have made homes for themselves and are living independently.

Her grades had been in the upper half of her class throughout elementary, junior high and senior school. She had been taking ballet lessons since she was a school girl and belonged to a gymnastic club in both junior and senior high school. While she was selfish and somewhat too self-assertive, probably because of her having been brought up indulgently as the youngest child, she had a strong independent spirit, a sense of responsibility, was sociable and had many friends.

After graduation from senior high school, she moved to Tokyo, relying upon aid from third elder sister. For several years, while employed as a typist and concurrently enrolled a training school of a famous ballet troupe, she was living in high spirits.

After three years, however, her father fell ill and was confined to bed, and she was forced to return home to care for him. Her father died soon after, and she returned to Tokyo one year later in spite of the opposition of her family.

While running a ballet class in the suburbs of Tokyo she was spending most of her time as a formal member of the above-mentioned ballet troupe. Finding it difficult to support herself with the income from the ballet class alone, she took odd jobs such as the delivery of newspapers or janitorial work. During this time her family heard nothing from her. And it was also at about this time that she experienced disappointment in love.

Present illness: Her life in Tokyo was hard, but "every day was worth living" to her because she was able to perform as an assistant to a leading ballerina in "The Sleeping Beauty" and the "Swan Lake" ballet which were presented by the troupe to which she belonged. At age 28 she left out of the selection process for members of the ballet troupe's overseas performance group because her height (1.42m) fell short of the minimum criterion. This was a terrible shock to her and for awhile thereafter she would rarely take meals, confining herself to her room every day.

After one month of such behavior she became healthy again, with restored pep and energy, without receiving any specific treatment.

However, three months thereafter, she began to have an odd feeling, that is, she felt as if she had become the heroine of "The Sleeping Beauty" and this feeling started manifesting itself in her daily behavior.

She began to hear a voice coming from nowhere telling her that she was Cinderella. She had an experience in which upon seeing a pumpkin she ordered it to become a carriage and then saw a vivid image of a carriage like the one pictured in an illustrated book.

She claimed that while practicing ballet, she did not feel that she was dancing by her own will, but instead felt as if she was a puppet controlled and manipulated by an unknown force. Further, she came to hear clearly a commanding voice ordering her to read the Koran. When she talked about this with her friends, none would believe her, so she began to consider the idea of seeing a psychiatrist.

At about this time, her family informed her of a prospective marriage partner so she decided to return home. There then arose a problem with the landlord concerning the deposit on the room that she rented for the ballet class. In addition, her one-side love affair ended in complete rupture. These events all combined to bring heavy pressure to bear upon her mental state.

Immediately after returning home, she visited the Department of Psychiatry for medical consultation and examination. Her dreamy state, auditory hallucinations and "gemachtes Erlebnis" disappeared after attending the Out-patient Clinic for two months. At this time she was living at home and helping out with the family business of carpentry.

In February, at the age of 29, she began showing odd behavior such as taking a walk under an umbrella when it was fine so she attended the Out-patient Clinic of the Department of Psychiatry for another two months in hopes of obtaining a remission. She stated she felt depressed somehow, but she appeared unable to describe the exact details of her unhappiness. Thus, a lowering of the level of consciousness was suspected. However, EEG records in the meantime showed no evidence of any abnormalities.

In June of the same year, she suddenly fell into a state of catatonic excitement. Saying that she could hear a voice demanding her death, she cut her neck and both wrists with a razor and subsequently was admitted to a surgical hospital for treatment. The excited state subsided one week later without her receiving any psychiatric treatment. After recovery, she began working as a waitress at a coffee shop while practicing ballet as a member of a local ballet company.

In October, immediately before the public performance of a ballet

in which she was to appear as one of the leading ballerinas, she became insomniac and exhibited odd behavior such as squatting in the corner of her room without speaking a word, running in the nude for 2000m on the road in front of her house and wandering aimlessly about a nearby mountain for nearly the whole night. Because of these actions she was admitted to the Psychiatric Ward of this university.

Findings on admission: She showed little expression save a gloomy face. From time to time she would act as if threatened. She spoke in so small a voice as to be hardly audible during history taking.

She showed little interest in events around her but responded relatively clearly to topics concerning ballet. When viewing ballet scenes on TV, she stated that she could enter the Braun tube so that she herself, sitting in front of TV, could view her other self dancing with the ballerinas on TV.

Physically, nothing remarkable was found.

Clinical course after admission: With a frozen expression she sat completely still in the corner of the ward and showed strongly negativistic behavior such as refusing to take food or medication. When questioned, she would not answer and at times she acted as if listening to something. Thus, the presence of auditory hallucinations was suspected.

Tube feeding and parenteral administration of neuroleptics were performed. Occasionally, catalepsy was observed, and at those times she needed help in urinary and fecal excretion. From the 13th day after admission, she was able to converse in a small voice and complained of feeling sorrowful and persecuted. She also expressed concern about the public performance of the ballet. At times she said she would not take meals because the shadow of a person ordered her "not to eat." From the 23rd day after admission, she began speaking on her own initiative and said, "I've been silent to punish my mouth which uttered criticizing words to my friends." "I'm afraid I've caused trouble for the public performance of the ballet. I wanted to die to make atonement for it. I attempted to commit suicide but was saved. So, I intended to die of starvation and thus I refused to take food." "I heard a voice say 'Don't eat,' but I think that was probably my own voice. I don't remember running nude on the street and wandering about the nearby mountain before admission."

From the 50th day after admission, she began to smile and came to teach a folk dance to some of the other patients.

Electroencephalogram showed slow activity of high voltage 6-7 Hz in a diffusive manner in all leads.

An anticonvulsant was then administered in small doses in combination with neuroleptics, whereupon her clinical course was improved. At this time the treatment was switched to ambulatory care after a stay of three and a half months in the hospital.

At present, one year after discharge, the so-called defect conditions have not been observed and she is leading a stable life at home while practicing ballet.

DISCUSSION

In discussing endogeneous psychoses, psychiatrists have been hampered by the dualistic theory of "Schizophrenia (dementia praecox) or manic-depressive psychosis" — the ghost of Kraepelin hovering in the domain of psychiatry even today half a century after his death. Of course it is not as if no attempts have been made to identify or classify diseases positioned between these two types of psychoses. For instance, definitions such as "Degenerationspsychosen" (Schroder 1920²⁾, Kleist 1921³⁾, "Mischpsychosen" (Gaupp u. Mauz 1926⁴⁾) and atypical psychoses (Mitsuda 1953⁵⁾) have been presented. These concepts have in turn given birth to various ideas such as "Phasische Psychosen" (Burger-Prinz 1961⁶⁾), "Legierungspsychosen" (Arnold et al. 1965⁷⁾) and "Randpsychosen" (Storring et al. 1962⁸⁾).

Many of the aforementioned authors were critical of trying to expand the usual schizophrenia zone, and they appeared to be making efforts to find some affinity within the domain of manic-depressive psychosis for those cases that could not easily be diagnosed as schizophrenia. Sawa (1957⁹⁾) was working in this direction by studying EEG findings and attempting to elucidate this question by considering epileptic factors in addition to schizophrenia and manic-depressive psychosis.

All this has made us realize that studies in this field are, so to speak, a bottomless swamp. As the above examples show, this gray area between schizophrenia and manic-depressive psychoses is in a chaotic state.

Because a full picture of that continent called schizophrenia has not yet been obtained psychiatrists facing such a nebulous situation are at a loss as to what to do. An example of this confusing state in psychiatry is the symptom of synchronous periodicity, which is said to be observed, though varying in degree, in about one third of the cases of schizophrenia after the onset of the disease¹⁰⁾.

This synchronism is, of course, usually mentioned as one of the most ubiquitous characteristics of affective psychoses, but, as is well known,

there do exist periodic schizophrenic disorders. In schizophrenic patients who show synchronous periodicity the disease takes the form of a cyclic manic-depressive psychosis, but schizophrenic behavior of the paranoid type or catatonic type is supposedly brought to the foreground. In such cases of schizophrenia where the manic phase can be distinguished clearly from the depressive phase, however, the atypical picture being discussed here is rarely seen, and instead an atypical pattern with a mixture of manic and depressive elements is likely to appear (Mentzos¹¹).

In such cases, following sleeplessness, irritability and depression, which are suggestive of neurasthenia, a vague "Wahnstimmung" and delusions of reference with anxiety as an underlying feature appear. If the manic element is then added to such cases then not only delusions of reference, delusions of persecution and "gemachtes Erlebnis", but also symptoms of hallucination consisting primarily of auditory hallucinations present themselves.

In this period, there is sometimes a simultaneous experience of anxiety and ecstasy; the patient is occasionally seized by the feeling that his world has collapsed and the feeling of other experiences of "a semi-realistic melodramatic kind, such as catastrophes, dangerous adventures, glimpses of heaven and hell" (Mayer-Gross¹⁰). If the illness advances further, the patient will fall into stupor or state of confusion which then leads to a change in the level of consciousness accompanied by catatonic behavior.

Clearness of consciousness is assumed to be a characteristic background of schizophrenia, but there is an exception to this general rule, rare as it is. That is the dream-like state observed in the early stages of it is. That is the dream-like state observed in the early stages of schizophrenia and catatonia. These catatonic stupors, at times, bring about a mental vacuum such that later the patient has no memory of his catatonic state. Acute catatonia presents the delirious picture without toxic or infectious somatic diseases. In cases where the disease develops in adolescence and marked symptoms of delusion and hallucination are observed, it will usually be labeled as schizophrenia.

According to K. Schneider¹², in such adolescent cases there will also be the "Class 1 symptom of schizophrenia." If observations are made carefully, however, pathological picture as described above can also be noted in the atypical picture of cyclic manic-depressive psychosis. The disease in such a case essentially different from true schizophrenia not only in the pre-disease character of the patient and the triggering of the

onset of the disease but also in the construction of the abnormal experience (Kimura¹³).

Schizoid behavior (Kretschmer¹⁴) comes to mind as the pre-disease character of schizophrenics. There also exists the inclination to both autism (Bleuler, E.¹⁵) and outright seriousness with no understanding of humor, while two extremes — sensitiveness and dullness — are mixed in varying ratios and seen at the same time. In other words, schizophrenia may be defined as the lack of ability to contact the outside world in a harmonious way.

By contrast, the case presented in this report an affinity for reality along with an orientation to system and order and had characteristics such as diligence, thoroughness and an excessive sense of obligation and responsibility which are rather suggestive of the pre-disease character in cases of manic-depressive psychosis. The difference between the schizophrenic and the manic-depressive can be observed in the course of the onset of the disease, too. In schizophrenics the clue as to what triggered the disease can be found in the life history of the patient whereas in atypical psychoses an accidental experience may serve as a focus for the patient's character and the circumstances in his life and in such a way be a causative factor.

Kimura¹³ is of the view that the pathological experience of the schizophrenic arises from confusion between "self" and "non-self." That is, the "self" converges on the center of "self", while at the same time expanding to infinity.

By contrast, the paranoid experience is one that occurs on a clearly demarcated boundary between the "self" and "non-self," with the paranoid "non-self" always attempting to invade the domain of the "self" from the outside. The tendency for the "self" to expand is not observed in such a case.

Lastly, I would like to refer to oneirophrenia (Meduna and McCulloch¹⁶). The patient in the oneirophrenic state is characterized by the experience of multiple scenic hallucinations and the loss of contact with all real surroundings, as if in a dream, and shows abnormal carbohydrate metabolism. Yet, oneirophrenia, like schizophrenia or manic-depressive disorder, cannot be said to be entirely consistent with the case under review.

There is no gainsaying that schizophrenia and manic-depressive psychosis are two different types of disease in the group of endogenous psychoses. But for cases of endogenous psychosis in which manifestations of basically different kinds appear periodically in an alternating

manner, however, we must, for the present, be satisfied with treating them as "atypical" or "mixed" (Meyer, H.H.¹⁾).

SUMMARY

The patient was a 30-year old unmarried woman. Her pre-disease character was marked by diligence, thoroughness and a strong sense of obligation and responsibility — all characteristics with affinity to manic-depressive psychosis.

At age 28, she fell into a depressed state on account of a psychological shock.

After recovering from this state, she then showed a dream-like state which was accompanied by auditory hallucinations and "gemachtes Erlebnis".

At age 29, she began to exhibit odd behavior, and at that time a lowering of the level of consciousness was also suspected. Four months later she presented a pathological picture suggestive of catatonic excitation. Automutilation was also observed but this episode was of short duration and the patient returned to normal within one week.

Subsequent episodes lasted one to two months.

The fifth episode started with a state of catatonic excitement and later, showed auditory hallucinations, visual hallucinations, "Wahnstimmung", delusion of culpability and negativism. This state lasted about two months.

Diffuse slow waves were recorded on EEG.

Judging from the periodicity seen in the clinical course, in combination with the lack of defusability observed in the paranoid symptoms and the lowering of the level of consciousness, the patient was considered to have atypical, or mixed, psychosis. Discussion was held on the relationship between this type of disorder on the one hand and schizophrenia and affective disorders on the other.

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